Liberty Mutual

PROOF OF TOTAL DISABILITY

Submitted to
LIBERTY LIFE ASSURANCE COMPANY OF BOSTON
BOSTON, MASSACHUSETTS

Mail to:
Liberty Life Assurance
Company of Boston
Group Life Claims
Mail Stop 03F
P.O. Box 1525
Dover, NH 03821-1525
1-800-210-0268 EXT: 36274
Fax No.: (603) 742-3873

(Before making out this statement, carefully read instructions on the back hereof)

CLAIMANT'S
STATEMENT

1. Name of Insured: ANTHONY P. SCAPICCHIO M.D	Policy Nos.
2. Present Address: No. 780 Street Boylston St. #6H City/Town Boston, MA Zip Code 02199	
3. Date and place of birth: Dec. 18, 1937 USA — Month December Day 18 Year 1937 — City or Town Everett State or Country MASS. USA	
4. Name and address of Insured's last employer: Mt AUBURN Hospital — Address No. Street 330 Mt Aub St City or Town CAMBRIDGE State MA 02138	
5. Occupation or duties of the Insured: Emergency Med. Physician	Emergency Medicine Physician
6. State all changes in occupation of the Insured since policy was issued.	Occupations / Year: NO CHANGES
7. Describe fully the nature and precise cause of disability sustained or contracted?	Obstructive Sleep Apnea + Daytime Somnolence
8. On what date was the injury or the disease causing disability sustained or contracted?	Month Dec. 1994 Day see orig applic.
9. Date Insured was obliged to cease work?	Month JAN. 1995 Day see orig applic
10. Does the disability now prevent the Insured from engaging in all work, occupation or business?	Answer Yes or No: YES see orig applic.
11. If the answer to question 10 is "Yes", from what date has the Insured been continuously prevented?	Month Jan 1995 Day see orig applic.
12. When is it expected that the Insured will be able to resume some gainful employment?	State approximate date: NEVER - Disease has NO MEDICAL ENDPOINT
13. If the Insured is now engaged in some work, occupation or business, on what date did this total disability cease?	Month Day: total disability HAS NOT CEASED
14. Is there a previous history of illness?	Not this condition
15. When did the Insured first consult or when was he first attended, treated or examined by a physician or other practitioner or first treated or examined in a hospital or other institution for or in connection with the disability?	Month Dec. 1994 Day see orig applic
16. State the names and addresses of all physicians or other practitioners and all hospitals or other institutions by whom or in which the Insured has been treated or examined for or in connection with the disability?	Name: Betsy Sherry MD — Mt Aub Hosp, Doctors Office Bldg, 300 Mt Aub St, CAMB, MA 02138

17. List all other Disability Coverage provided by the Liberty Life Assurance Company of Boston or any other Insurance Company of Boston or any other Insurance Company, Governmental Agency, Union Welfare Plan or employer-employee benefit organization.

Name of Organization	Policy Numbers	Amount of Benefit Weekly	Monthly
Soc Sec Adm	024 28 8555		1316/1397

See Enclosed Copy of current LTD Benefit Stmt from Liberty Mutual.
Claim # 114766

DP 605 GL 12/01

Total Dis EE